

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Cavetown Pike

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural Hagerstown
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Hubert E. Bagent

3. (b) Social Security Number

215-07-4255

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married8. (b) Name of husband or wife Mary Bagent

7. Birth date of

deceased (mo., day, yr.)

January 28, 1903

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

42722

hrs.

min.

9. Birthplace Hagerstown, Wash. Md.
(Town, county, and state)10. Usual occupation Silk Weaver

11. Industry or business

MOTHER FATHER

12. Name

Albert Bagent

13. Birthplace

Washington County, Md.

14. Maiden name

Elizabeth Shank

15. Birthplace

Washington County, Md.16. Informant Mrs. Hubert BagentAddress Hagerstown, Md. R F D17. Burial Date thereof Sept. 23, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Md.18. Funeral director Fred W. KraissAddress Hagerstown, Md.19. Sept. 23, 1945
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20, 1945 at 11:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15 to 19 1945
and that I last saw him alive on 19

Immediate cause of death

Coronary Thrombosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address Hagerstown, Md. Date signed Sept 21/45

RECEIVED
SEP 25 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09302

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 20 Years
 Hospital, institution, or street address where death occurred:
408 Guilford Ave.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 408 Guilford Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Anna Belle Baker

3. (b) Social Security Number

No

4. Sex

F

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife..... William H. Baker

7. Birth date of

deceased (mo., day, yr.)

June 12, 1888

6. (c) If alive, give age..... years

8. AGE:

Years

57

Months

2

Days

21

If less than one day

..... hrs. min.

9. Birthplace

Franklyn County, Penna

(Town, county, and state)

10. Usual occupation

Home work

11. Industry or business

FATHER
MOTHER

12. Name

Charles Spencer

13. Birthplace

Frankltn County, Penna

14. Maiden name

Laura Shields

15. Birthplace

Franklyn County, Penna.

16. Informant

William H. Baker

Address

Hagerstown,17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... Sept 7, 1945

(month) (day) (year)

Cemetery or crematory

Rest Haven

Location

Hagerstown

18. Funeral director

Fred W. Kraiss

Address

Hagerstown19. Sept 5

(Date rec'd by registrar)

19 45Chas. H. Bowers

Registrar

MEDICAL CERTIFICATION

7²⁵20. DATE OF DEATH..... Sept 3rd 19 45 at P.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1-45 19 45 to Sept 3 45and that I last saw her alive on Sept 3-45 19 45

Immediate cause of death

Ischemic

DURATION

4 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

.....Date of op.....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE

W. D. Bowers

M. D. or other

Address..... Hagerstown Date signed 9/4/45

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SEP 7 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hancock
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Donna Lavonne Barnhart

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

B. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) March 4, 1943

6. (c) If alive, give age _____ years

8. AGE: Years 2 Months 6 Days 3
If less than one day _____ hrs. _____ min.9. Birthplace Fulton County, Pa.
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name James Barnhart13. Birthplace Fulton Co., Pa.14. Maiden name Gwendolyn Hann15. Birthplace Fulton Co., Pa.16. Informant James BarnhartAddress Hancock, Md.17. Burial Date thereof Sept. 10, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Days Chapel CemeteryLocation Hancock, Md. R F D18. Funeral director Snyder-Rowland Funeral HomeAddress Hancock, Md.19. Sept. 11, 1945 Blanch Brown
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7, 1945 4:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2 1945 to Sept 7 1945and that I last saw Sept 7 1945 alive on Sept 7 1945

Immediate cause of death _____ DURATION _____

Congenital heart _____malformation _____

Due to _____

Patent foramen _____ovale _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Dr. M. Shaffer M.D.Hancock, Md. 9/10/45

Address _____ Date signed _____

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SEP 13 1945
BUREAU V.R.

Dr. Crady, ~~Dr. Crady~~

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09304

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
 City or town... Smithsburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 weeks
 Hospital, institution, or street address where death occurred:
Crash Co. Hospital
 How long in hospital or institution? 9 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Smithsburg (If outside city or town limits, write RURAL and give nearest town)
 Street No... Boonsboro Md. R. 2
 (If rural, give LOCATION)
 2.(a) If veteran, name war... None

3. (a) FULL NAME

Mary Ann Beard

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Geo. C. Beard
 6. (c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.) November 15, 1885
 8. AGE: Years 85 Months 10 Days 15 If less than one day... hrs. ... min.

9. Birthplace Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

12. Name William Jones

13. Birthplace Wash. Co. Md.

14. Maiden name Susan Beachley

15. Birthplace Wash. Co. Md.

16. Informant William A. Jones

Address Boonsboro Md. R. 2

17. Burial Date thereof Oct. 4, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Smithsburg Cemetery

Location Smithsburg Md.

18. Funeral director Wm J. Best & Sons

Address Boonsboro Md.

19. Oct. 2, 1945 Beath Brothers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30, 1945, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27, 1945 to Sept. 30, 1945 and that I last saw him alive on Sept. 29, 1945

Immediate cause of death Pericardial Hemorrhage DURATION 10 days

Due to Fracture of femur 12-4 days

Due to Accidental fall, July 27th, 1945, near

Due to Boonsboro, Washington County, Maryland

Other conditions Stalk, on hip, stepping with heel

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of July 27th, 1945

Where did injury occur? Boonsboro, Washington, Maryland
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) At home

Means of injury Accidental fall Injured at work?

23. SIGNATURE James M. D. M. D. or other

Address Boonsboro, Md. Date signed 10/1/45

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OCT 4 1945

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

09305

302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Co. Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 1210 Virginia Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Bell, Mollie E.

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

F

W

Married

6.(b) Name of husband or wife J. Frank Bell

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) Jan. 10, 1878

8. AGE:

Years

Months

Days

If less than one day

67

8

3

hrs.

min.

9. Birthplace Washington Co., Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Brenanam Wolfkill13. Birthplace Washington Co., Md.14. Maiden name Emma J. Stouffer15. Birthplace Washington Co., Md.16. Informant J. Frank BellAddress Hagerstown, Md.17. Burial Date thereof 9/16/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rest HavenLocation Hagerstown, Md.18. Funeral director L. F. ReecherAddress Funkstown, Md.19. Sept. 15, 45 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 19 45 at 8:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 21 19 45 to Sept. 13 19 45and that I last saw her alive on Sept. 13 19 45

Immediate cause of death

Chronic myocarditis

DURATION

years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Hagerstown, Md. Date signed 9/15/45

13/11/1945

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SEP 18 1945
BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Washington
City or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
29 E. Salisbury St.
How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 29 E. Salisbury St.
(If rural, give LOCATION)
2. (a) If veteran, name war 2

3. (a) FULL NAME

Barbara Ellen Bramble

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Charles W. Bramble

6. (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1914

8. AGE: Years 70 Months 9 Days 13 If less than one day _____ hrs. _____ min.

8. Birthplace Williamsport Wash. Co Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business House

12. Name John W. Long

13. Birthplace Williamsport Md

14. Maiden name Mary E. Gansh

15. Birthplace Williamsport Md

16. Informant Mrs Ethel P. Long

Address Williamsport Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Sept. 8 1945
(month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland Maryland

18. Funeral director Edith V Leaf

Address #7 Church St. Williamsport, Md.

19. Sept. 7 45 - Mrs E L McElroy
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 19 45, at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 19 19 45, to Sept. 6 19 45, and that I last saw him alive on Sept. 5 19 45.

Immediate cause of death _____ DURATION

Cerebral Hemorrhage 17 days

Due to Aortic Aneurysm 2 years

Due to _____

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations none

_____ Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide NO Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John W. Long M. D. or other

Address Williamsport Md Date signed 9/6/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 19 1945
BUREAU V.S. H

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1224)

CERTIFICATE OF DEATH

Dr. Layman

09307

★ Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24 Hours
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 24 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1161 Hamilton Blvd
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

Harry v Troupe Brewer

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Sarah Ann

6. (c) If alive, give age 65 years
 7. Birth date of deceased (mo., day, yr.) October 17 1873

8. AGE: Years 71 Months 11 Days 27 If less than one day hrs. min.

9. Birthplace Cleersprings Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Real Estate

11. Industry or business Operator

12. Name D. Louis Brewer

13. Birthplace Cleersprings Md.

14. Maiden name Mary E. Troupe

15. Birthplace Cleersprings Md.

16. Informant D. Russell Brewer

Address Baltimore Md.

17. Burial Date thereof 9/6/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Sept 6 19 45 Black Bower

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH September 4 1945 at 1130 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 3 1945 to Sept 4 1945
 and that I last saw him alive on Sept 4 1945

Immediate cause of death Toxemia DURATION

Due to Intestinal obstruction

Due to Adhesions and Volvulus

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations no operation

Autopsy results as stated

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. L. Layman M.D.

Address Hagerstown Md. M. D. or other

Date signed 9/5/45

RECEI

SEP 8 1945

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 132

09308

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH

County WashingtonCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 wks

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 2 wks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa County FranklinCity or town Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Waynesboro
(If rural, give LOCATION)2.(a) If veteran, name war ✓

3. (a) FULL NAME

Dennis Eugene Burger

3. (b) Social Security Number

4. Sex male5. Color or race white6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1940
6. (c) If alive, give age 4 years8. AGE: Years 5 Month 1 Days 12 If less than one day
hrs. min.9. Birthplace Waynesboro Pa
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name Lloyd Lester Barnhart Burger13. Birthplace Greencastle #1 Pa14. Maiden name Russana Mae Barnhart15. Birthplace Waynesboro, Pa16. Informant R.W. BarnhartAddress Waynesboro #3 Pa17. Burial Date thereof 9/30/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Green HillLocation Waynesboro, Pa18. Funeral director John J. HoutAddress 171 Church St. Waynesboro, Pa19. Sept-27, 1945 Health Officers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27 19 45 at 9:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9/1 19 44 to 9/27 19 45and that I last saw him alive on 9/26 19 45Immediate cause of death Tuberculous Meningitis

DURATION

2 wks

Due to

Due to

Other conditions Pulmonary tuberculosis

(Include pregnancy within 8 months of death)

Major findings of operations noneAutopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J.C. BrevittAddress Greencastle Pa M. D. or other 9/27/45
Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 1 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B12)

09309

CERTIFICATE OF DEATH

Reg. Dist. No. 316

1. PLACE OF DEATH:

County Washington
 City or town Kedysville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 52 years
 Hospital, institution, or street address where death occurred:
Main St.
 How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Kedysville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Main St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Emma Catherine Burtner

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

8. (b) Name of husband or wife O. W. Burtner

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1875

8. AGE: Years Months Days If less than one day

70 6 3 hrs. min.

9. Birthplace near Middletown Fred. Co. Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. Name Joshua E. Look13. Birthplace near Middletown Fred. Co. Md.14. Maiden name Lydia E. Look15. Birthplace near Middletown Wash. Co. Md.18. Informant O. W. BurtnerAddress Kedysville Md.17. Burial Date thereof Oct. 2, 1945
(Burial, cremation, or removal) Which? (month) (day) (year)Cemetery or crematory Sourview CemeteryLocation Kedysville Md.18. Funeral director Wm. J. Bart & SonAddress Boonsboro Md.19. Oct 1, 1945 R. H. Keeting
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29, 1945 at 12:26 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

about 1945 to Sept. 29, 1945and that I last saw him alive on Sept. 28, 1945Immediate cause of death Coronary Vascular - Heart Disease

DURATION

3 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter H. Shady M.D.

M. D. or other

Address Shurpsbury, Md. Date signed 10/1/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Shady

RECEIVED
OCT 3 1943
BUREAU A.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

09310

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town near Dunkstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hagerstown Md R.BHow long in hospital or institution at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town near Dunkstown 'Rural'
(If outside city or town limits, write RURAL and give nearest town)Street No. Hagerstown Md. R.3
(If rural, give LOCATION)

2.(a) If veteran, same war

3. (a) FULL NAME

C. Keller Clark

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife Single7. Birth date of deceased (mo., day, yr.) March 9 - 1882

8. AGE: Years Months Days If less than one day

63 6 20 hrs. min.9. Birthplace near Dunkstown Wash. Co. Md.
(Town, county, and state)10. Usual occupation Farmer11. Industry or business -12. Name Benjamin F. Clark13. Birthplace Virginia14. Maiden name Mary Jane Harman15. Birthplace Wash. Co. Md.16. Informant Mrs. M. J. Neal Rokeastle Md.17. Burial Date thereof Oct. 3, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Dunkstown CemeteryLocation Dunkstown Md.18. Funeral director Wm. J. Baat & SonsAddress Brownstown Md.19. Oct. 21 45 East Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September - 29 - 1945 at 3.30 P. M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 1945 to Sept 29 1945and that I last saw him alive on Sept 1 1945

Immediate cause of death

Cancer of lungs; secondary.Due to Cancer of faceDue to Duration 5 yearsOther conditions Cut

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. F. ratherAddress Hagerstown Md.Date signed 10/1/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 4 1945
BUREAU V.B.

Change of name: letter
shown in Microfilm as:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (546)

19311

★ Reg. Dist. No. 302

FILM No. 100 FEB 28 1946

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Washington
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 618 West Franklin Street
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

William Alfred Cosens

3. (b) Social Security Number

220-10-3985

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Erma L. Cosens
6. (c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) June 29, 1879
8. AGE: Years 66 Months 2 Days 29 If less than one day hrs. min.

9. Birthplace Hagerstown, Wash. Co. Md
(Town, county, and state)
10. Usual occupation Stock Clerk
11. Industry or business Fairchild's Aircraft Co.
12. Name Henry J. Cosens
13. Birthplace England
14. Maiden name Georgina Gooch
15. Birthplace Scotland

16. Informant Walter Cosens
Address Hagerstown, Maryland
17. Burial Date thereof 9-29-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rest Haven Cemetery
Location Hagerstown, Maryland
18. Funeral director C. M. Suter & Sons
Address Hagerstown, Maryland
19. Sept. 29, 1945 W. H. Boward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept/ 27 1945 19... at 3:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19... to 19... and that I last saw him alive on 19...

Immediate cause of death Generalized vascular arteriosclerosis DURATION 2yr s

Due to Brain tumor, metastatic, Primary

Due to Encephalitis site, unknown, curable

Other conditions Malignant Papillary adenocarcinoma, scattered throughout cerebral hemispheres. Duration: 8 months.
(Include pregnancy within 3 months of death)

Major findings of operations no Date of op.

Autopsy results no PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Robert & Mills, M.D. M. D. or other

Address Hagerstown Md Date signed Sept. 28/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 2 1945

BUREAU V.S.

Evidence for change of year of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

09312

★ Reg. Dist. No. 302

MM "G 98 OCT 4 1945

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One Day
Hospital, institution, or street address where death occurred:
Washington Co. Hospital
How long in hospital or institution? One Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Clearspring, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3.(a) FULL NAME

Olive Blanche Cunningham

3.(b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Divorced

6.(b) Name of husband or wife _____ 6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Dec. 18 1896- 1899

8. AGE: Years 45 Months 3 Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace Washington County
(Town, county, and state)

10. Usual occupation Home Work

11. Industry or business

FATHER 12. Name Nelson Harsh
13. Birthplace Washington County

MOTHER 14. Maiden name Idella Shank
15. Birthplace Washington County

16. Informant Mrs. Olivia Griffin
Address Clearspring, Md Rural

17. Burial Date thereof Sept. 12 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St Pauls
Location Near Clearspring Md.

18. Funeral director Snyder - Rowland
Address Clearspring, Md.

19. Sept. 11 19 45 David A. Brewer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 19 45, at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 7 19 45 to Sept 9 19 45
and that I last saw him alive on Sept 9 19 45

Immediate cause of death Diabetic Coma DURATION 16 hrs

Due to Diabetes Mellitus 2 yrs.

Due to _____

Other conditions Infection of foot 2 weeks
(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE David A. Brewer M.D. M. D. or other
Address Clear Spring Md. Date signed 9/10/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 13 1945

BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

09313

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington CountyCity or town Hagerstown Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? V

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? V

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Downsville Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No. Downsville Md.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

Alfred Irvin Dick

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Ellen E Barrett Dick6.(c) If alive, give age 55 years

7. Birth date of

deceased (mo., day, yr.)

Aug 3 1883

8. AGE:

Years

Months

Days

If less than one day

62113

.....hrs.

.....min.

9. Birthplace Downsville Md.

(Town, county, and state)

10. Usual occupation

Stone Mason

11. Industry or business

John Shank (built walls)

MOTHER FATHER

12. Name

George Dick

13. Birthplace

Downsville Md.

14. Maiden name

Ellen R Hines

15. Birthplace

Trego Md.

16. Informant

Ellen E Barrett

Address

Downsville Maryland

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof Sept. 21 1945
(month) (day) (year)

Cemetery or crematory

Greenlawn Cemetery

Location

Williamsport, Maryland

18. Funeral director

Edith V Leaf

Address

#7 Church St. Williamsport, Md.

19.

Sept 20 45
(Date read by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1945 at 1:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15 1945 to Sept 16 1945
and that I last saw him alive on Sept. 16 1945

Immediate cause of death

Starvation -

DURATION

Due to

Carcinoma or old
ulcer of esophagus and
stomach.

Other conditions

Stricture or occlusion
of esophagus
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. W. Williams M.D.
M. D. or other
Address Hagerstown Md. Date signed 9/17-45

RECEIVED
SEP 22 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

09314



Reg. Dist. No. 302

1. PLACE OF DEATH: County..... Washington City or town..... Hagerstown (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... 21 Years Hospital, institution, or street address where death occurred: 321 Mitchell Ave. How long in hospital or institution?.....		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... Maryland..... County..... Washington City or town..... Hagerstown (If outside city or town limits, write RURAL and give nearest town) Street No..... 321 Mitchell Ave. (If rural, give LOCATION) 2.(a) If veteran, name war..... No	
--	--	---	--

3. (a) FULL NAME Charles A. Dickens	3. (b) Social Security Number 173/ o3/ o685
--	--

4. Sex Male	5. Color or race White	6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife..... Bessie M.		
7. Birth date of deceased (mo., day, yr.) April 14. 1879.		

8. AGE:	Years 66	Months 4	Days 20	If less than one day hrs. min.
---------	-------------	-------------	------------	--

9. Birthplace..... (Town, county, and state)	Virginia
---	----------

10. Usual occupation.....	Mechanist
---------------------------	-----------

11. Industry or business.....	Fairchild Aircraft Co.
-------------------------------	------------------------

12. Name.....	William Dickens
---------------	-----------------

13. Birthplace.....	Virginia
---------------------	----------

14. Maiden name.....	Frances Peed
----------------------	--------------

15. Birthplace.....	Virginia.
---------------------	-----------

16. Informant.....	Charles G. Dickens Jr.
--------------------	------------------------

Address.....	Hagerstown
--------------	------------

17. Burial (Burial, cremation, or removal. Which?)	Date thereof..... Sept 5 1945 (month) (day) (year)
---	---

Cemetery or crematory.....	Rest Haven
----------------------------	------------

Location.....	Hagerstown
---------------	------------

18. Funeral director.....	Fred W. Kraiss.
---------------------------	-----------------

Address.....	Hagerstown
--------------	------------

19. Sept 5 19 45 (Date registered by registrar)	Blair H. Bowers Registrar
--	------------------------------

MEDICAL CERTIFICATION		8 ¹⁵ 35
20. DATE OF DEATH.....	Sept 2nd	19 45 at P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20 19 45 to Sept 2 19 45 and that I last saw him alive on Sept 2 19 45
--

Immediate cause of death..... Coronary Occlusion	DURATION 14 days
---	---------------------

Due to.....	
-------------	--

Due to.....	
-------------	--

Other conditions.....	Mesenteric Thrombosis	2 days
-----------------------	-----------------------	--------

(Include pregnancy within 3 months of death)	
--	--

Major findings of operations.....	
-----------------------------------	--

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....	Date of.....
-------------------------------------	--------------

Where did injury occur?	(City or town)	(County)	(State)
-------------------------------	----------------	----------	---------

Injured at home, farm, industry, public place (where?)
--

Means of injury.....	Injured at work?
----------------------	------------------

23. SIGNATURE.....	Ost Binkley	M. D. or other
--------------------	-------------	----------------

Address.....	Hagerstown, Md	Date signed 9/4/45
--------------	----------------	--------------------

RECEIVED
SEP 7 1945
BUREAU V. S.

Dr. Pohl
808 2nd Avenue
2nd - 940
M
MARGIN RESERVED FOR BINDING
VS A15
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-2

CERTIFICATE OF DEATH

09315

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington

City or town... Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 hours

Hospital, institution, or street address where death occurred:

Wash. Co. Hospital

How long in hospital or institution? 24 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington

City or town... Gaithersburg 'Rural'
(If outside city or town limits, write RURAL and give nearest town)Street No... Gaithersburg Md.
(If rural, give LOCATION)

2.(a) If veteran, name war... None

3.(a) FULL NAME

John Edward Cardley

3.(b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

8.(b) Name of husband or wife

Marie Cardley

7. Birth date of

deceased (mo., day, yr.)

December - 18 - 1872

8.(c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

72

8

28

hrs.

min.

9. Birthplace

England

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

Retired

FATHER

12. Name

Joseph Cardley

13. Birthplace

England

14. Maiden name

Mary Ann Cardley

15. Birthplace

England

16. Informant

Mrs. Marie Cardley

Address

Gaithersburg Md.

17. Burial, cremation, or removal. Which?

Burial

Date thereon

Sept. 10, 1945

Cemetery or crematory... Greenwood Cemetery

Location

Ashbury Park N.J.

18. Funeral director

Wm. J. Bast & Sons

Address

Baltimore Md.

19.

Sept 7 19 45

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

2b. DATE OF DEATH... Sept 6th 19 45 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 6 19 45 to Sept 6 19 45

and that I last saw him alive on Sept 6 19 45

Immediate cause of death

Acute Congestive Heart

Due to

Failure

Due to

Pulmonary Edema

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Ernest F. Pohlman

M. D. or other

Address

Gaithersburg Md.

Date signed Sept 7 19 45

RECEIVED
SEP 10 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-0

CERTIFICATE OF DEATH

09316

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Washington CountyCity or town Pinesburg Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 monthsHospital, institution, or street address where death occurred:
Williamsport, Md. RFD #2 Pinesburg

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Pinesburg Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. Williamsport, Md. RFD #2
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Harriet Rebecca Elliott

3. (b) Social Security Number

None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Female</u>	<u>White</u>	

6. (b) Name of husband or wife William Elliott
deceased6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) May 29 1889

8. AGE:	Years	Months	Days	If less than one day
<u>56</u>				_____ hrs. _____ min.

9. Birthplace Pennsylvania
(Town, county, and estate)10. Usual occupation Housewife11. Industry or business Home12. Name James Mills13. Birthplace Pa.14. Maiden name Ella Stothplen15. Birthplace Pa.16. Informant Mrs. Franklin JonesAddress Pinesburg Md. Williamsport RFD #217. Burial Date thereof Sept. 18 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Montgomery CemeteryWelsn Run Pa.Location Edith V Leaf18. Funeral director #7 Church St. Williamsport, Md.Address Sept 18 '45 Mrs E Lee McElroy

19. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1945, at 9:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 1945 to Sept 14 1945and that I last saw him alive on Sept 14 1945Immediate cause of death Large tumor mass in region of ascending colon, probably carcinoma.Due to ascending colon, probably carcinoma.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results not done.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Manner of injury _____ Injured at work?

23. SIGNATURE E. M. Pinner M. D. or other _____Address Williamsport Md. Date signed 9/17/45

RECEIVED
SEP 20 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-27

CERTIFICATE OF DEATH

09317 302
Reg. Dist. No.

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Washington Co. Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington
 City or town..... Clearspring Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Girl Baby Of Mr. & Mrs. Chester Ernst

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Sept. 3 1945

8. AGE:

Years

Months

Days

It less than one day

000

hrs.

15

min.

9. Birthplace

Hagerstown Md.
(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

FATHER
MOTHER

12. Name

Chester Ernst

13. Birthplace

Washington County

14. Maiden name

Louise Firey

15. Birthplace

Washington County

16. Informant

Chester Ernst

Address

Clearspring, Rural

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Sept. 4 1945
(month) (day) (year)

Cemetery or crematory

St. Pauls Cemetery

Location

Near Clearspring Md.

18. Funeral director

Snyder - Rowland

Address

Clearspring, Md.

19.

Sept. 4 1945
(Date filed by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept 3, 1945 at 99 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 3, 1945 to Sept 3, 1945
and that I last saw him alive on Sept 3, 1945

Immediate cause of death

DURATION

Birth Pressure Sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

David P. Brewer
Clear Spring Md. M. D. or other
Address..... Date signed 9/3/45

RECEIVED
SEP 6 1945
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... WashingtonCity or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 45 Years

Hospital, institution, or street address where death occurred:

370 Virginia AveHow long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 370 Virginia Ave
(If rural, give LOCATION)2.(a) If veteran, name war... None

3. (a) FULL NAME

Mrs. Mollie A. Smith Ernst

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow6. (b) Name of husband or wife John G.

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) September 8 1864

8. AGE: Years Months Days If less than one day

8105

...hrs. ...min.

9. Birthplace Hagerstown Wash. Co. Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name John Smith13. Birthplace Germany14. Maiden name Catherine Seal15. Birthplace Germany16. Informant William ErnstAddress Hagerstown Md.17. Burial Date thereof 9/15/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill Cemetery- MausoleumLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Sept 15, 45 Westbourne
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13 1945 at 4 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 11, 1945 to Sept. 13 1945and that I last saw her alive on September 13, 1945 1945Immediate cause of death Pulmonary Edema DURATION e2 daysDue to Chronic myocarditis with congestive failure Indef.Due to General arteriosclerosis Indef.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

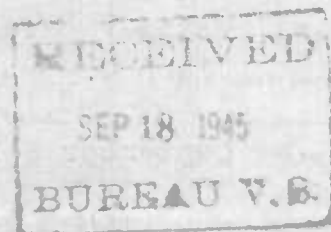
Means of injury Injured at work?

23. SIGNATURE B. B. Kneisley M.D. M. D. or otherAddress 148 W. Washington St., Date signed 9/14/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-D

CERTIFICATE OF DEATH

09319

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Hagerstown Route #4
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Hagerstown Route #4
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Helen Virginia Fiery

3. (b) Social Security Number

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Single</u>	
6.(b) Name of husband or wife			
6.(c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>March 2, 1849</u>			
8. AGE: Years <u>96</u>	Months <u>6</u>	Days <u>1</u>	If less than one dayhrs.min.

9. Birthplace Hagerstown, Wash. Co. Md.
(Town, county, and state)
10. Usual occupation Retired Housekeeper
11. Industry or business

FATHER	12. Name <u>Benj. F. Fiery</u>
	13. Birthplace <u>Hagerstown, Maryland</u>
MOTHER	14. Maiden name <u>Ann S. Beckley</u>
	15. Birthplace <u>Hagerstown, Maryland</u>

16. Informant H. J. McCarragher
Address Hagerstown Route #4

17. Burial Date thereof 9-5-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown, Maryland
C. M. Suter & Sons

18. Funeral director
Address Hagerstown, Maryland

19. Sept 5, 1945
(Date rec'd by registrar) Registrar Charles H. Bowers

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3 19 45, at 11 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-28-45 19 45, to 9-3-45 19 45, and that I last saw alive on 9-2-45 19 45.

Immediate cause of death
Due to Senility
Due to Ch. Myocarditis
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. or other
Address Hagerstown, Md. Date signed 9/8/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 7 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown and R.R. 4
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 weeks
 Hospital, institution, or street address where death occurred:
Hagerstown Md. R.D. #4
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Penn. County ...
 City or town Homer City Pa
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. ...
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Mrs Mary Emma Foster

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 8.(b) Name of husband or wife Esley Foster
Husband 6.(c) If alive, give age ... years
 7. Birth date of deceased (mo., day, yr.) August 5 - 1900
 8. AGE: Years 45 Months 1 Days 5 If less than one day ... hrs. ... min.

9. Birthplace Opton Pa.
(Town, county, and state)10. Usual occupation House work

11. Industry or business

12. Name Morris Skinner13. Birthplace Huntington Co. Pa.14. Maiden name Anna Ester15. Birthplace Chambersburg Pa R.R. 416. Informant Esley FosterAddress R.D. #4 Hagerstown Md.17. Burial Date thereof Sept 12, 45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fair View CemeteryLocation Mercersburg Pa.18. Funeral director The LuningorAddress Mercersburg, Pa.19. Sept 10 19 45 Health Officers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10, 1945 at 5:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 12, 1945 to Sept 10, 1945and that I last saw him alive on September 7, 1945Immediate cause of death Hypertension -vascular - renal disease

DURATION

2Due to ...Due to ...Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations No operationsAutopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...Where did injury occur? ... (City or town) (County) (State)Injured at home, farm, industry, public place (where?) ...Means of injury ... Injured at work? ...23. SIGNATURE Ra BellAddress Hagerstown Md. Date signed 9/10/45

UNITED STATES DEPARTMENT OF JUSTICE

STATE OF NEW YORK

RECEIVED
SEP 12 1945
BUREAU P.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Dr. Ditto 09321 125

★ Reg. Dist. No. 302

1. PLACE OF DEATH: County... <u>Washington</u> City or town... <u>Maugansville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?... <u>9 years</u> Hospital, institution, or street address where death occurred: <u>Maugansville</u> How long in hospital or institution?... <u>None</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State... <u>Maryland</u> County... <u>Washington</u> City or town... <u>Maugansville</u> (If outside city or town limits, write RURAL and give nearest town) Street No... <u>No Name</u> (If rural, give LOCATION) 2.(a) If veteran, name war... <u>None</u>			
3. (a) FULL NAME <u>Mrs. Sarah Ann Hartranft</u>				3. (b) Social Security Number <u>None</u>			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Widow</u>		MEDICAL CERTIFICATION	
6. (b) Name of husband or wife <u>Samuel D.</u>				20. DATE OF DEATH <u>September 27 1945</u> 19 <u>45</u> , at <u>9.10</u> <u>PM</u>			
7. Birth date of deceased (mo., day, yr.) <u>January 4 1874</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Aug 1-45</u> 19 <u>45</u> <u>Sept 27</u> 19 <u>45</u> and that I last saw <u>for</u> <u>alive on</u> <u>Sept 22-45</u> 19 <u>45</u>			
8. AGE: Years <u>71</u> Months <u>8</u> Days <u>23</u> If less than one dayhrs.mo.		6. (c) If alive, give age years		Immediate cause of death		DURATION	
9. Birthplace <u>Welsh Run Franklin Co. Pa.</u> (Town, county, and state)				<u>Ch. Myocarditis</u>		<u>4 yrs</u>	
10. Usual occupation <u>Housewife</u>				Due to.....		
11. Industry or business <u>Own Home</u>				Due to.....		
12. Name <u>David Minnich</u>				Other conditions.....		
13. Birthplace <u>Manheim Pa.</u>				<u>Arterio sclerosis</u> (Include pregnancy within 3 months of death)		
14. Maiden name <u>Katherine Ruhl</u>				Major findings of operation	
15. Birthplace <u>Manheim Pa.</u>				
16. Informant <u>Miss Katherine M. Hartranft</u> Address <u>Maugansville Md.</u>				Autopsy results		PHYSICIAN: Please underline the cause to which death should be charged statistically.	
17. Burial (Burial, cremation, or removal. Which?) Cemetery or crematory <u>Dunkard Cemetery</u> Location <u>Broadfording Md.</u>				22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....		
18. Funeral director <u>Andrew K. Coffman</u> Address <u>Hagerstown Md.</u>				23. SIGNATURE <u>S. W. Dittus</u> M. D. or other <u>Hagerstown</u>		Address..... Date signed <u>9/28/45</u>	
19. (Date rec'd by registrar) <u>Sept. 28 45</u> Registrar <u>Blanch Howard</u>				Address..... Date signed.....			

RECEIVED
OCT 1 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 119-2

CERTIFICATE OF DEATH

09322

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County... WashingtonCity or town... Punkstown Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Route 40 S. Punkstown, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Punkstown Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Route 40 South
(If rural, give LOCATION)

2.(o) If veteran, name war...

3. (a) FULL NAME

Charles Edgar Hays

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1943 6. (c) If alive, give age... years

8. AGE:

Years

1

Months

9

Days

21

If less than one day

... hrs. ... min.

9. Birthplace... Hagerstown, Wash. Co., Md.
(Town, county, and state)10. Usual occupation... None

11. Industry or business

FATHER

12. Name... Charles E. Hays13. Birthplace... Greencastle, Pa.

MOTHER

14. Maiden name... Helen E. McDermott15. Birthplace... Belington, W. Va.16. Informant... Mrs. Helen E. HaysAddress... Punkstown, Md. RFD17. Burial Date thereof... Sept. 29, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Rose Hill CemeteryLocation... Hagerstown, Md.18. Funeral director... Fred W. KraissAddress... Hagerstown, Md.19. Sept. 28, 45 Registrar
(Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... September 26, 1945 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 27 - 45 to Sept 26 - 45and that I last saw him... alive on Sept 26 - 45 19...

Immediate cause of death... DURATION

Due to fatal infarct 1 week

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... M. D. or other

Address... Date signed...

RECEIVED
OCT 1 1945
BUREAU V.S.

Evidence for addition of
age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09323 302

FILE No. G 98 SEP 18 1945

1. PLACE OF DEATH:
County Washington
City or town Dunkirk
(if outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Wash. Co. Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Dunkirk
(if outside city or town limits, write RURAL and give nearest town)
Street No. Main St.
(if rural, give LOCATION)
2. (a) If veteran, name war none

3. (a) FULL NAME Clayton E. Houpt

3. (b) Social Security Number none

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
6. (b) Name of husband or wife Jennie Houpt
6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 8, 1875
8. AGE: Years 70 Months 5 Days 29 It less than one day
hrs. min.

9. Birthplace Mt. Lena Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name Cornelius Houpt

13. Birthplace Mt. Lena Wash. Co. Md.

MOTHER 14. Maiden name Amanda Stettin

15. Birthplace Wolfville Fred. Co. Md.

16. Informant Mrs. Virgie Reese

Address Dunkirk Md.

17. Burial Date thereof Sept 11, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro, Md.

18. Funeral director W & Bost & Sns

Address Boonsboro, Maryland

19. Sept. 9, 45 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7, 1945 19 45 10:55 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8, 1945 to Sept 7, 1945
and that I last saw him alive on Sept 5, 1945

Immediate cause of death Hypertensive Cardiac
vascular disease

DURATION

Due to 5 yrs

Due to

Other condition Cerebral Hemorrhage 4 days

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

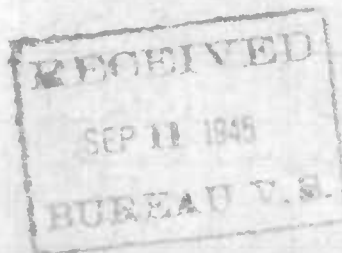
23. SIGNATURE Audrey Hovester M.D. M. D. or other

Address Dunkirk Md. Date signed 9/8/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

09324

Reg. Dist. No.

302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:
17 East Avenue Hagerstown md.

How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 17 East Avenue
(If rural, give LOCATION)

2.(a) If veteran, name War None

3. (a) FULL NAME

Sidney Hughes

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Catharine Hughes

7. Birth date of deceased (mo., day, yr.) October 23, 1875
6.(c) If alive, give age years

8. AGE: Years 69 Months 11 Days 7 If less than one day hrs. min.

9. Birthplace Bedford Penna.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Finton Hughes

13. Birthplace Funkstown Wash. Co. Md.

14. Maiden name Mary Smith

15. Birthplace Bedford Penna.

16. Informant Paul Hughes

Address Boonsboro Md. R.1

17. Burial Date thereof Oct. 4, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Salem Cemetery

Location near Mapleville Md.

18. Funeral director Wm J. Bast & Sons

Address Boonsboro Md.

19. Oct. 2, 45 Blair Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30, 1945 at 8-P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death generalized vascular arterio-sclerosis DURATION 2yrs

Due to acute coronary occlusion

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations no

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert Wells DEPUTY MEDICAL EXAM.

Address Hagerstown Md. Date signed Oct. 1/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Wells.

CERTIFICATE OF DEATH

RECEIVED
OCT 4 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

09325

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

412 Linganore Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)Street No. 548 Wilson Blvd. West
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Isaac Newton Hull

3.(b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Anna Hull

7. Birth date of

deceased (mo., day, yr.)

April 3, 1871

6.(c) If alive, give age..... years

8. AGE:

Years

74

Months

5

Days

20

If less than one day

hrs.

min.

9. Birthplace

Fulton County, Pa.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER
MOTHER

12. Name

Henry Hull

13. Birthplace

Fulton County, Pa.

14. Maiden name

Mary Eichelberger

15. Birthplace

Fulton County, Pa.

16. Informant

Mrs. Grace Hull

Address

412 Linganore Ave- Hagerstown, Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

Sept. 25, 1945

(month) (day) (year)

Cemetery or crematory

Spring Mills Cemetery

Location

Near Marlowe, W. Va.

18. Funeral director

Fred W. Kraiss

Address

Hagerstown, Md.

19.

Sept. 25, 1945

(Date rec'd by registrar)

45Clark Powers

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23, 1945 10:30 at A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1922

19

to Aug. 27

19

and that I last saw him alive on Aug. 27

19

Immediate cause of death

Myocarditis, Chronic

DURATION

Due to

Bronchial asthma -

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. D. Powers M.D.

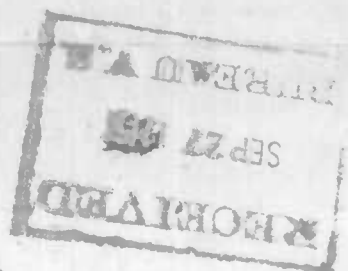
M. D. or other

Address

Hagerstown, Md.

Date signed

9/24/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Victor Miller 113
09320

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 Months
 Hospital, institution, or street address where death occurred:
352 South Potomac St.
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 352 South Potomac St.
 (If rural, give LOCATION)
None
 2.(a) If veteran, name war... None

3. (a) FULL NAME

Mrs. Lillian Andrews Jones

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Benj. R.
 6. (c) If alive, give age 71 years
 7. Birth date of deceased (mo., day, yr.) February 18 1874
 8. AGE: Years 71 Months 7 Days 10 If less than one day
hrs. min.

9. Birthplace Charlestown Middlesex Co. Mass
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name M. Berry Andrews

13. Birthplace Portland Me.

MOTHER 14. Maiden name Fannie McKean

15. Birthplace Portland Me.

16. Informant Mrs. E.A. Kenner

Address Williamsport Md. R # 2

17. Cremation Date thereof 9/20/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Washington D.C.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Sept. 19, 1945 Chas. H. Boward
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Sept. 18 1945 19... at 7.30 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Sept 1 - 44 to Sept 18 - 45
 and that I last saw him alive on Sept 18 19 45

Immediate cause of death

Carcinoma of Large Colon -
 DURATION 5-6 years.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Victor Miller

M. D. or other

Address Date signed 9/19 1945

RECEIVED
SEP 21 1945
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

CERTIFICATE OF DEATH

09327

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one year

Hospital, institution, or street address where death occurred:

34 Braxton Ave.How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 34 Braxton Ave.

(If rural, give LOCATION)

2.(a) if veteran, name war none

3. (a) FULL NAME

Leonard L. Kane

3. (b) Social Security Number

none

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Fannie5. (c) If alive, give age 45 years7. Birth date of deceased (mo., day, yr.) May 7, 1886

8. AGE: Years Months Days if less than one day

59329

.....hrs.min.

9. Birthplace Winchester, Va.

(Town, county, and state)

10. Usual occupation Laborer11. Industry or business Laborer12. Name John Kane13. Birthplace Winchester, Va.14. Maiden name Lizzie Kane15. Birthplace Winchester, Va.16. Informant Mrs. Fannie KaneAddress 34 Braxton Ave17. Burial Date thereof Sept. 8, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rosedale CemeteryLocation Martinsburg, W. Va.18. Funeral director Andrew K. CoffmanAddress Hagerstown, Md.19. Sept 6 1945 Registrar Charles Bowser

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5, 1945 19 45 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Sept 5 - 9:15 Sept 6 - 4:45and that I last saw him alive on Sept 6 - 4 19 45

Immediate cause of death

Carcinoma
(Face)

DURATION

6 mo

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Dr. [Signature]Address Hagerstown, Md. M. D. or otherDate signed Sept 6 1945

158-3

UNITED STATES DEPARTMENT OF JUSTICE

STANDARD FORM NO. 100-10

RECEIVED
SEP 8 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Dr. Ditto 19328

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Maugansville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 Mos

Hospital, institution, or street address where death occurred:

Maugansville Nursing HomeHow long in hospital or institution? 8 Mos

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Maugansville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Maugansville Nursing Home

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

Mrs. Martha Ann Keedy

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow6. (b) Name of husband or wife Josephus6. (c) If alive, give age - years7. Birth date of deceased (mo., day, yr.) November 3 1853

8. AGE: Years Months Days If less than one day

91 10 25 hrs. min.9. Birthplace Boonsboro Wash. Co. Md.

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business Own HomeFATHER 12. Name Frederick Keefauver13. Birthplace Boonsboro Md.MOTHER 14. Maiden name Margaret Huntzberry15. Birthplace Boonsboro Md.16. Informant Mr. Harry E. KeedyAddress Hagerstown Md.17. Burial Date thereof 9/30/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fairview CemeteryLocation Keedysville Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Oct. 1, 45 Chas H Bowers

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH September 28 1945 at 3.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1-45 19 Sept 28-45 19and that I last saw him alive on Sept 20-45 19

Immediate cause of death

Senility

Due to

Due to

Other conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. W. Smith M. D. or otherAddress Hagerstown Md. Date signed 9/29/45

RECEIVED
OCT 3 1966
BUREAU V.H.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 17 Berner Ave

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME

John Lester Kriner Sr.

3.(b) Social Security Number

173-03-3928

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widower6.(b) Name of husband or wife Mary Jane6.(c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.)

June 14 1890

8. AGE:

Years

Months

Days

If less than one day

5536

hrs.

min.

9. Birthplace Waynesboro Franklin Co. Pa.

(Town, county, and state)

10. Usual occupation Machinist11. Industry or business Md. Machine & Foundry Wks.12. Name John L. Kriner13. Birthplace Waynesboro Pa.14. Maiden name Ida Miller15. Birthplace Waynesboro Pa.16. Informant John Lester Kriner Jr.Address Hagerstown Md.17. Burial Date thereof 9/22/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Prices cemeteryLocation near Waynesboro Pa.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Sept 20 45 Chas H Bowers
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/20/45 19... at... M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9/19/45 19... to 9/20/45 19...
and that I last saw him alive on 9/19/45 19...

Immediate cause of death

DURATION

Cerebral hemorrhage3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Hagerstown Md Date signed 9/20/45

RECEIVED

SEP 22 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09330

Reg. Dist. No. 9.05

1. PLACE OF DEATH:

County Washington
City or town San Mar
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Salisbury Memorial Home
Stay in hospital or inst. (yrs., or mos., or days) 3 years
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 2101 Penrose Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR none ✓

3. (a) FULL NAME

Amy Lane
4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

B (b) Name of husband or wife No Record

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) February - 18 - 1870

8. AGE: Years 75 Months 7 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Dover Delaware
(Town, county, and state)

10. Usual occupation none

11. Industry or business _____

12. Name Samuel Thomas Jones

13. Birthplace Denton Md.

14. Maiden name Mary Rebecca Bennett

15. Birthplace Dover Delaware

16. Informant Mrs. Roland Oman

Address 2101 Penrose Ave. Baltimore Md.

17. Burial Date thereof Oct. 3, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Falmers Cemetery

Location near Mapleville Md.

18. Funeral director W. J. East & Sons

Address Brownsville Md.

19. Oct. 2, 1945 John H. East
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30, 1945 19 45, at P. 6:30 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 19 45, to September 30 19 45, and that I last saw him alive on September 28 19 45.

Immediate cause of death _____ DURATION _____

Chronic Myocarditis.
Due to _____

Due to _____

Other conditions _____

Major findings: _____

Of operations _____

(Include pregnancy within 3 months of death)

Of autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE G. W. Llewellyn M.D. M. D. or other _____

Address Brownsville, Md. Date signed 9/30/45

PHYSICIAN

Please underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

BUREAU 4 B

OCT 4 1945

RECORDED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

Reg. Dist. No. 09331 305

1. PLACE OF DEATH:

County... Washington
 City or town... near Boonsboro Rural
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4.5 years
 Hospital, institution, or street address where death occurred:
Boonsboro Md. R. 2
 How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... near Boonsboro Rural
(If outside city or town limits, write RURAL and give nearest town)
 Street No. Boonsboro Md. R. 2
(If rural, give LOCATION)
 2. (a) If veteran, name war... None

3. (a) FULL NAME

Mary Nancy Lemon

3. (b) Social Security Number

None

4. Sex Female 5. Color or Race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Charles M. Lemon
 6. (c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.) January - 10 - 1867
 8. AGE: Years 78 Months 8 Days 16 If less than one day... hrs. ... min.

9. Birthplace Myersville Fred. Co. Md.
(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business Own home

12. Name Ezekiah Cline

13. Birthplace Myersville Fred. Co. Md.

14. Maiden name Barbara Marker

15. Birthplace Myersville Fred. Co. Md.

16. Informant Mrs. Russell Moser

Address Boonsboro Md. R. 2

17. Burial Date thereof Sept. 29, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md.

19. Funeral director Wm. J. Bast & Sons

Address Boonsboro Md.

19. Sept. 29 19 45 Wm. J. Bast
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 19 45 at 11:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 20 19 45 to Sept. 26 19 45 and that I last saw him alive on Sept. 26 19 45

Immediate cause of death Cerebral Hemorrhage DURATION 6 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Hubert Wade, M.D. M. D. or other

Address Boonsboro, Md. Date signed 9/27/45

RECEIVED
OCT 1 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

09332

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County FREDERICK Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

125 Fairground Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 125 Fairground Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Roy Simon Long

3. (b) Social Security Number

4. Sex male

5. Color or race white

6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Bessie Nora Petre

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Oct. 13th 1881

8. AGE: Years 63 Months 11 Days 10 If less than one day hrs. min.

9. Birthplace Washington Co. Md
(Town, county, and state)

10. Usual occupation Minister (Retired)

11. Industry or business

12. Name Isaac Simon Long

13. Birthplace Washington Co. Md

14. Maiden name E. Estella Hagerman

15. Birthplace Washington Co. Md.

16. Informant Mildred Long Fischer

Address 125 Fairground Ave.

17. Burial Date thereof Sept. 29, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Md.

18. Funeral director L. F. Reecher

Address Funkstown, Md.

19. Sept 27 1945 Black H. Spaword
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 1945 at 1:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 14 1945 to September 23 1945

and that I last saw him alive on September 22 1945

Immediate cause of death

Acute Coronary occlusion

Due to

Due to

Other conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. H. Spaword M. D. or other

Address Hagerstown, Md. Date signed 9/25/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

CERTIFICATE OF DEATH

RECEIVED
OCT 1 1945
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09333

1. PLACE OF DEATH:

County..... Washington
 City or town..... Camp Ritchie
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 42 days
 Hospital, institution, or street address where death occurred:
Station Hospital, Camp Ritchie, Md.
 How long in hospital or institution?..... ten minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Minnesota County..... unknown
 City or town..... Minneapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 2708 Lynn Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... World War II ✓

3. (a) FULL NAME

Riley F. McKoy Lt Col 0289530

3. (b) Social Security Number

unknown

4. Sex..... M 5. Color or race..... W 6.(a) Single, married, widowed, or divorced..... M

6.(b) Name of husband or wife..... Glady's I. McKoy

7. Birth date of deceased (mo., day, yr.)..... May 24 1906 6.(c) If alive, give age..... unknown years

8. AGE: Years..... 39 Months..... 3 Days..... 1 If less than one day..... hrs. min.

9. Birthplace..... Pome, Georgia
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name..... unknown13. Birthplace..... Douglas County, Ga.14. Maiden name..... unknown15. Birthplace..... Douglasville, Ga.

16. Informant.....

Address.....

17. removal Date thereof..... 24 Sept 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director..... M. L. CresgerAddress..... Thurmont, Md.

19. 25 Sep 45
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 24 September 1945 at 9:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
8:50 PM 24 Sept 1945 to 9 PM 24 Sept 1945

and that I last saw him..... alive on 24 September 1945

Immediate cause of death..... coronary occlusion DURATION

Due to..... cause undetermined

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... John F. J. M. D. Capt, M.C.M. D. or other

Address..... Sta Hosp, Camp Ritchie, Md. Date signed..... 25 Sep 45

RECEIVED
SEP 26 1965
BUREAU A.P.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

CERTIFICATE OF DEATH

Dr. Bell

09334

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 Years
 Hospital, institution, or street address where death occurred:
140 South Locust St.
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 140 South Locust St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

John Mellinger

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife

-

7. Birth date of deceased (mo., day, yr.) February 18 1877

8. (c) If alive, give age - years

8. AGE:	Years	Months	Days	If less than one day
	68	7	1	hrs. min.

9. Birthplace Waynesboro Franklin Co., Pa.
(Town, county, and state)10. Usual occupation City Employee11. Industry or business Sweeper12. Name No Record13. Birthplace No Record14. Maiden name No Record15. Birthplace No Record16. Informant Mrs. Anna B. ReelAddress Hagerstown Md.17. Burial Date thereof 9/23/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. View CemeteryLocation Sharpsburg Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Sept. 20 45 Registrar Phyllis Bowers
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 1945 at 9:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 19, 1945 to Sept. 19, 1945
 and that I last saw him alive on September 19, 1945

Immediate cause of death Hypertension cardiovascular
renal disease.
 DURATION 2

Due to

Due to

Other conditions Senile dementia
DURATION 2

(Include pregnancy within 3 months of death)

Major findings of operations No operations

Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ra Bell
M. D. or otherAddress Hagerstown Md. Date signed 9/20/45

RECEIVED

SEP 22 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

09335

Reg. Dist. No.

307

1. PLACE OF DEATH:

County Washington
City or town Dargan, Md. Rural Near
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Harpers Ferry, W.Va. R.R. # 1
Stay in hospital or inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) 2mo 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Dargan, Md. Rural Near Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Harpers Ferry, W.Va. R.R. # 1
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Wayne Arthur Mitchell

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife *****
***** 6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 11 1945
8. AGE: Years 0 Months 2 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Hagerstown, Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business None

12. Name Orval C. Hays

13. Birthplace Hagerstown, Md.

14. Maiden name Frances E. Waters

15. Birthplace Dargan, Md.

16. Informant Frances E. Mitchell

Address Harpers Ferry, W.Va. R.R. # 1

17. Burial Date thereof Sept 25 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location Samuels Manor, Md.

18. Funeral director J. H. Backus

Address Bolivar, W.Va.

19. Sept 25 19 45 Cornelius H. Coats
(Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1945 - 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Birth 1945, to Sept 24 1945, and that I last saw him alive on Sept 24 1945.

Immediate cause of death Prematurely DURATION 1 week

7 months baby

Major findings: _____

Of operations _____

Of autopsy _____

Of conditions Prematurely

7 months baby

(Include pregnancy within 8 months of death)

Physician _____

Please underline the cause to which death should be charged statistically.

Of violence: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Walter A. Shady M.D. M. D. or other _____

Address Charpsburg, Md. Date signed 9/24/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 4 1946
BUREAU A.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year of birth of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (61)

Dr. Novenstene

FILED G 98 OCT 4 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 605 North Mulberry St.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

Mrs. Leila Catherine Mohler

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Edwin M

8. (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.)

May 28 1858 1869

8. AGE:

Years

Months

Days

If less than one day

76

3

29

hrs.

min.

9. Birthplace Rocky Ridge Fred. Co. Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

FATHER
MOTHER

12. Name

John C. Whitmore

13. Birthplace

Rocky Ridge Md.

14. Maiden name

Mary C. Newman

15. Birthplace

Rocky Ridge Md.

16. Informant

Edwin E. Mohler

Address

Hagerstown Md.

17.

Burial

Date thereof

9/9/45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rest Haven cemetery

Location

Hagerstown Md.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19.

(Date rec'd by registrar)

Sept 8

45

Bluff Tavern

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 1945 at 12.15 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 3 to Sept. 7 1945

and that I last saw her alive on Sept. 7 1945

Immediate cause of death

Uremia

DURATION

4 days

Due to

Hypertensive - Cardio-vascular disease

Due to

Other condition

Diabetes Mellitus

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

Lidney Novenstene M.D.
Hagerstown Md 9/2/45

RECEIVED
SEP 11 1945
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09337

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 years
 Hospital, institution, or street address where death occurred:
Leansboro Pike
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 222 West Side Avenue
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles W. Monahan

3. (b) Social Security Number

214-09-7849

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced	
<u>Male</u>	<u>White</u>	<u>Married</u>	
6. (b) Name of husband or wife... <u>Pauline McC. Monahan</u>			
6. (c) If alive, give age... <u>48</u> years			
7. Birth date of deceased (mo., day, yr.) <u>May 27, 1897</u>			
8. AGE:	Years	Months	Days
	<u>48</u>	<u>4</u>	<u>3</u>
If less than one dayhrs.min.			

9. Birthplace... Vineland, N.J.
 (Town, county, and state)
 10. Usual occupation... Coal Driver
 11. Industry or business... Abel Miller Co.

12. Name... Michael F. Monahan
 13. Birthplace... Vineland, N.J.
 14. Maiden name... Charlotte Maul
 15. Birthplace... Vineland, N.J.

16. Informant... Mrs. Charles Monahan
 Address... Hagerstown, Maryland

17. Burial Date thereof... 10-4-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Rose Hill Cemetery
 Location... Hagerstown, Maryland

19. Funeral director... C. M. Suter & Sons
 Address... Hagerstown, Maryland

19. Oct. 3 19 45 Health Bureau
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

Sept/30/458P

20. DATE OF DEATH..... 19..... at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death...
coronary heart disease
acute coronary occlusion

DURATION
2mo

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations... no

..... Date of op.

Autopsy results... no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... no Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work? DEPUTY MEDICAL EX23. SIGNATURE S. Robert Wells WASH CO. MD.Address... Hagerstown, Md. Date signed 10/2/45

RECEIVED
OCT 5 1945
BUREAU V.B.

RECEIVED
OCT 5 1945
BUREAU V.S.

Co. Health Officer
COPY SENT TO ~~LOCAL REGISTRY~~ DATE 10/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

09339

302

Reg. Dist. No.

1. PLACE OF DEATH:
 County Washington
 City or town Sagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days
 Hospital, institution, or street address where death occurred:
Wash. Co. Hospital
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Washington
 City or town near Boonsboro Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Boonsboro Md. R. 2
 (If rural, give LOCATION)
 2.(a) If veteran, name war home

3. (a) FULL NAME Anna Mae Morrison 3. (b) Social Security Number None

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Clyde Morrison
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) December - 19. 1894

8. AGE: Years 50 Months 9 Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace Wolfsville Ind. Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name Walter Stettinmeyer

13. Birthplace Wolfsville Ind. Co Md.

MOTHER 14. Maiden name Emma Hansen

15. Birthplace Garfield Ind. Co. Md.

16. Informant Clyde Morrison

Address Boonsboro Md. R. 2

17. Burial: (Burial, cremation, or removal. Which?) Burial Date thereof Sept. 30. 1945
 (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md.

18. Funeral director Wm. S. Bast & Sons

Address Boonsboro Md.

19. Sept. 28. 45 Registrar Boonsboro
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September - 28. 19. 45 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25 19. 45 to Sept 28 19. 45
 and that I last saw him alive on Sept 27 19. 45

Immediate cause of death Cardiac dilatation
myocarditis ch
 Due to 2 day's gastric
disturbance mellitus

DURATION
9/27/45
?
?
?

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE H. S. Porterfield M.D. M. D. or other _____

Address 136 W Washington Date signed 9/28/45

Dr. Porterfield

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 1 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(1860)

CERTIFICATE OF DEATH

Dr. Campbell

100

09340

302

Reg. Dist. No.

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 weeks

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 10 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 606 Washington Ave

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

Joseph Edward Moser

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Sallie E.8.(c) If alive, give age 64 years

7. Birth date of

deceased (mo., day, yr.)

January 24 1873

8. AGE:

Years

Months

Days

If less than one day

72713

hrs.

min.

9. Birthplace Sabillasville Fred. Co. Md.

(Town, county, and state)

10. Usual occupation Engineer-Retired11. Industry or business W.M.R.R.12. Name Joseph Moser13. Birthplace Sabillasville Md.14. Maiden name Mary Jane McClain15. Birthplace Sabillasville Md.16. Informant Mrs. J. Edw. MoserAddress Hagerstown Md.17. Burial Date thereof 9/8/45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Sept 8 45 Chas. Howard
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 1945 at 10 A

21. I CERTIFY that death occurred on the date above stated; that it attended deceased from

July 26 1943 to Sept 7 1945
and that I last saw him alive on Sept 6 1945

Immediate cause of death

Acute Cardiac Failure - 72 minutes

DURATION

Due to Accidental Fall 10-12-47 Sept 26/45Due to Fract. ribs 41Due to Acute lobar pneumoniaOther conditions Decomated face - Fract. right radiusAcute nephritisSevere diarrhoea

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statitically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? Hagerstown Washington Md.

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) HomeMeans of injury Fell from ladder Injured at work? No23. SIGNATURE Dr. Campbell M. D. or otherAddress Hagerstown Md. Date signed Sept 7/45

RECEIVED

SEP 11 1945

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days
 Hospital, institution, or street address where death occurred:
Wash. Co. Hospital
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Lapland (If outside city or town limits, write RURAL and give nearest town)
 Street No. Lapland md.
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

David Daniel Mullendore

3. (b) Social Security Number

269-18-5387

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Hazel Mullendore

7. Birth date of

deceased (mo., day, yr.)

December - 31 - 1879

8.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

6586

hrs.

min.

9. Birthplace

Lapland Wash. Co. md.
(Town, county, and state)

10. Usual occupation

Retired Farmer

11. Industry or business

FATHER

12. Name

Edward C. Mullendore

13. Birthplace

Lapland Wash. Co. md.

MOTHER

14. Maiden name

Laura Beeler

15. Birthplace

Lapland Wash. Co. md.

16. Informant

Mrs. Hazel Mullendore

Address

Lapland md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Sept. 10, 1945
(month) (day) (year)

Cemetery or crematory

Church of the Brethren Cemetery

Location

Brownsville md.

16. Funeral director

Wm. J. Bast & Sons

Address

Brownsville md.

19.

(Date rec'd by registrar)

Sept. 9, 1945
Black/Bowers

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

September 7, 1945 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 23, 1945 to Sept. 7, 1945and that I last saw him alive on Sept. 7, 1945

Immediate cause of death

Lung & heart

DURATION

3 weeks

Due to

Coronary Thrombosis6 weeks

Due to

Arteriosclerosis of the

Other conditions

hypertrophy prostate?

with

arteriosclerosis of aorta10 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Walter H. Shealy M.D.
Sharpsburg, Md. Date signed 9/9/45

M. D. or other

RECEIVED
SEP 11 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (127)

CERTIFICATE OF DEATH

Dr. Zimmerman

09342

105

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County... WashingtonCity or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 Days

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 9 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 1906 Virginia Ave

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

Harry Grafton Myers

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife... Myrtle6. (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.)

May 8 1876

8. AGE:

Years

Months

Days

If less than one day

69329

hrs.

min.

9. Birthplace... Sharpsburg Wash. Co. Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Retired

FATHER

12. Name

Jacob C. Myers

13. Birthplace

Sharpsburg Md.

MOTHER

14. Maiden name

Ann Cookerly

15. Birthplace

Sharpsburg Md.16. Informant... Mrs. Mary Smith

Address

Portsmouth Va.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

9/10/45

(month) (day) (year)

Cemetery or crematory

Mountain View Cemetery

Location

Sharpsburg Md.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19.

(Date read by registrar)

Sept. 10 1945 Phyllis Bowers

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... September 7 1945 19... 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 25 1940, to Sept. 7 1945
and that I last saw him alive on Sept. 7 1945

Immediate cause of death

DURATION

Pneumonia, general12 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M.D. or other

Address

Date signed

RECEIVED
SEP 12 1945
BUREAU V. O.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
age is shown on
FILE NO. G 98 SEP 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95)

CERTIFICATE OF DEATH

No 4

09343

305

Reg. Dist. No.

1. PLACE OF DEATH:

County WashingtonCity or town Bondules

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

St. Paul St.How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Bondules

(If outside city or town limits, write RURAL and give nearest town)

Street No. St. Paul St.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

4. Sex Male5. Color or race White6.(a) Single, married, widowed, or divorced MarriedB.(b) Name of husband or wife Myrtle Nety7. Birth date of deceased (mo., day, yr.) April 13, 18876.(c) If alive, give age 58 years8. AGE: Years 58 Months 56 Days 4 If less than one day

.....hrs.min.

9. Birthplace Bondules Wash. Co. Md.

(Town, county, and state)

10. Usual occupation Labourer11. Industry or business Victa Products Corp.12. Name John Nety13. Birthplace near Bondules Wash. Co. Md.14. Maiden name Annie Catherine Martin15. Birthplace near Bondules Wash. Co. Md.16. Informant Mrs. Myrtle NetyAddress Bondules Md.17. Burial Date thereof Sept 10, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bondules CemeteryLocation Bondules Md.18. Funeral director Wm J. Bait & SonsAddress Bondules Md.19. Sept 9 1945 John H. Bait Registrar

(Date rec'd by registrar)

3. (b) Social Security Number

213-12-7217

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7, 1945 at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 10, 1945 to Sept 7, 1945and that I last saw him alive on Sept 7, 1945

Immediate cause of death

DURATION

Left decompensationof the heart.

Due to

Large abscess of buttocks

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. W. Lelan M.D.

M. D. or other

Address Bondules Date signed 9/9/45

RECEIVED TO THE UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED TO THE UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

SEP 11 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Miller

09344

302

Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 years
 Hospital, institution, or street address where death occurred:
626 Potomac Ave
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 626 Potomac Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Mrs. Anna Ringer Orrick

3. (b) Social Security Number

None

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Lewis J.
 7. Birth date of deceased (mo., day, yr.) November 13 1869
 8. AGE: Years 75 Months 10 Days 6 If less than one day hrs. min.

9. Birthplace Boonsboro Wash. co. Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home
 FATHER 12. Name T. Biser Ringer
 13. Birthplace Boonsboro Md.
 MOTHER 14. Maiden name Alice Derr
 15. Birthplace Boonsboro Md.
 16. Informant Lewis J. Ringer
 Address Hagerstown Md.

17. Burial Date thereof 9/22/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
Hagerstown Md.
 Location
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Sept. 20 45 Registrar Charles Toward
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 1945 at 11.30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 to Sept 19 1945
 and that I last saw him or her alive on 9/19 1945

Immediate cause of death Carcinoma of Colon
 DURATION 2-3 years

Due to —
 Due to —

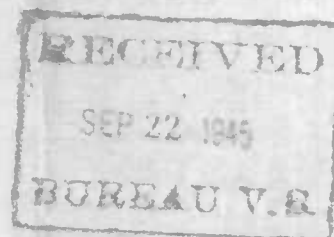
Other conditions —
 (Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results 0
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide — Date of —
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) —
 Means of injury — Injured at work? —

23. SIGNATURE V. Miller M. D. or other
 Address — Date signed 9/20-1945



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No. 19302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:
300 Vale Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 300 Vale Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Samuel F. Pike

3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Ida C. Pike

7. Birth date of deceased (mo., day, yr.) Dec 4, 1868 6.(c) If alive, give age 76 years

8. AGE: Years 76 Months 9 Days 15 If less than one day
.....hrs.min.

9. Birthplace Franklin County, Pa.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Pattern maker.

12. Name Louis Pike

13. Birthplace Franklin County, Pa.

14. Maiden name Mary Jane Snyder

15. Birthplace Franklin County Pa.

16. Informant Mrs. Ida C. Pike

Address 300 Vale Street- Hagerstown, Md.

17. Burial Burial Date thereof Sept. 24, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Broadfording Cemetery

Location Near Clearfoss, Md.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. Sept. 23, 1945 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21, 1945 5:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30, 1945 to September 21, 1945
and that I last saw him alive on September 16, 1945

Immediate cause of death Coronary occlusion DURATION 13 min
Due to Coronary artery sclerosis
with coronary spasm
Due to Generalized arterio sclerosis
Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide 0 Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury 0 Injured at work?

23. SIGNATURE Chas H Bowers M. D. or other

Address Hagerstown, Md. Date signed 9/21/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 25 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 958

CERTIFICATE OF DEATH

09346

118

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?

3. (a) FULL NAME

Helen M. Rossman

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Guy Rossman

7. Birth date of

deceased (mo., day, yr.)

Aug. 21, 18846. (c) If alive, give age. 66 years

8. AGE:

61 Years0 Months27 Days

If less than one day

.....hrs.min.

9. Birthplace

Near Chambersburg Frank. Pa.

(Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

Own HomeFATHER
MOTHER

12. Name

George A. Ryder

13. Birthplace

Near Mercersburg Pa.

14. Maiden name

Maria Deatrich

15. Birthplace

Near Mercersburg Pa.

16. Informant

Mr. Guy Rossman

Address

Middleburg Md.

17.

Burial

Date thereof

9/18/45

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Beautiful View Cemetery

Location

Middleburg Md.

18. Funeral director

Scott F. Minnich & Son

Address

Hagerstown Md.

19.

Sept 20 1945

(Date filed by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town

Middleburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 1945 at 5:05p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9/171945to 9/181945

and that I last saw her alive on

9/181945

Immediate cause of death

Rheumatic heart disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. C. Bowers, M.D.

M. D. or other

Address

Greencastle, Pa.

Date signed

9/19/45

RECEIVED
SEP 22 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 yearsHospital, institution, or street address where death occurred:
68 1/2 E. Franklin St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 68 1/2 E. Franklin St.

(If rural, give LOCATION)

None

2. (a) If veteran, name war

3. (a) FULL NAME

Fanny G. Schulze

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

MarriedB. (b) Name of husband or wife William Schulze6. (c) If alive, give age 69 years7. Birth date of deceased (mo., day, yr.) July 28, 18728. AGE: Years 73 Months 1 Days 11 If less than one day
.....hrs.min.9. Birthplace Near Clairbrooke Fred. Va.
(Town, county, and state)10. Usual occupation House Wife11. Industry or business Own Home12. Name Hugh Jenny13. Birthplace Loudon Co. Va.14. Maiden name Ellis Riely15. Birthplace Welltown Va.16. Informant Miss. Ellen E. JanneyAddress Hagerstown Md.17. Burial Date thereof Sept 12, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. HebronLocation Winchester Va.18. Funeral director Scott F. Minnich & SonAddress Hagerstown Md.19. Sept. 11, 1945 Registrar Charles H. Bowers
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9, 1945 19. at 11:20p M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 16, 1945 to Sept. 8, 1945
and that I last saw or alive on Sept. 7, 1945Immediate cause of death Tubercular meningitis

DURATION

June 2, 1945Due to arteriosclerosis10 yrs +

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None.Date of op. —Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? X X X
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE W. Howard Gyeager M. D. or otherAddress Hagerstown, Md Date signed 9-10-45

Received

RECEIVED
SEP 13 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 60 East Franklin Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

William Albert Sellman

3. (b) Social Security Number

214-09-4820

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower
 6.(b) Name of husband or wife Maud Sellman
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) December 4, 1883
 8. AGE: Years 61 Months 9 Days 22 If less than one day..... hrs. min.

9. Birthplace Hagerstown Wash.Co.Md
 (Town, county, and state)
 10. Usual occupation Auto mechanic
 11. Industry or business Troy Laundry
 12. Name Charles W. Sellman
 13. Birthplace Mt. Airy, Maryland
 14. Maiden name M. Katherine Hood
 15. Birthplace Mt. Airy, Maryland

16. Informant Wayne Sellman
 Address Hagerstown, Maryland
 17. Burial Date thereof 9-28-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland
 18. Funeral director C.M.Suter & Sons

Address Hagerstown, Maryland
 19. Sept 28 45
 (Date rec'd by registrar) Blasch/Bowers
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1945 at 5:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....
 and that I last saw h..... alive on..... 19.....

Immediate cause of death.....
Diabetic acidosis and coma 20hrs
(Mellitus)
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... no..... Date of op.....
 Autopsy results..... no
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... no..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE J. Robert Wells M.D.
 Address..... Hagerstown, Md. Date signed 9/28/45

RECEIVED
OCT 1 1945
BUREAU V.S.

RECEIVED
SEP 11 1945
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

CERTIFICATE OF DEATH

No 3

Reg. Dist. No. 4935505

1. PLACE OF DEATH:

County... Washington
 City or town... Boonsboro
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 months
 Hospital, institution, or street address where death occurred:
N. Main St.
 How long in hospital or institution? on Street

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Boonsboro
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. N. Main St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war... None

3. (a) FULL NAME

Mary Casselia Shipley

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife... Emmett Shipley
 6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) March 4, 1884

8. AGE: Years 61 Months 6 Days 1 It less than one day hrs. min.

9. Birthplace near Bakersville Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation... Housekeeper

11. Industry or business

12. Name... Christian M. Paffenberger

13. Birthplace Bakersville Wash. Co. Md.

14. Maiden name... Mary A. Fine

15. Birthplace Keedysville Wash. Co. Md.

16. Informant... Miss Pearl Paffenberger

Address Keedysville Md.

17. Burial Date there... Sept. 8, 1945

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory... Boonsboro Cemetery

Location Boonsboro Md.

18. Funeral director... Wm. J. Best & Sons

Address Boonsboro Md.

19. Sept. 8 1945 John H. Best

(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... September - 5 - 1945, at 9:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 5 1945, to Sept 5 1945

and that I last saw him live on Sept 5 1945

Immediate cause of death Fracture skull

Due to Compound fracture of

Due to both legs below knee

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 9/5/45

Where did injury occur? Boonsboro Wash. Co. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) street

Means of injury struck by auto Injured at work?

23. SIGNATURE S. E. W. Smith

M. D. or other

Address Hagerstown Md. Date signed 9/7/45

RECEIVED
SEP 11 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 756

CERTIFICATE OF DEATH

09351

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 27 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution?..... 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 713 George St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... -

3. (a) FULL NAME

Bessie M. Smith

3. (b) Social Security Number

4. Sex..... female 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... married
 6.(b) Name of husband or wife..... Norman S. Smith
 6.(c) If alive, give age..... 57 years
 7. Birth date of deceased (mo., day, yr.)..... October 18, 1893
 8. AGE: Years..... 51 Months..... 10 Days..... 27 It less than one day..... hrs. min.

8. Birthplace..... Charlton, Washington, Md.
 (Town, county, and state)
 10. Usual occupation..... Housewife
Own Home
 11. Industry or business.....
 12. Name..... George Shank
 13. Birthplace..... near Four Locks, Md.
 14. Maiden name..... Mary Houpt
 15. Birthplace..... near Hancock, Md.

16. Informant..... Norman S. Smith
 Address..... Hagerstown, Md.

17. Burial Date thereof..... Sept. 18, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Rest Haven Cemetery
Hagerstown, Md.
 Location.....

18. Funeral director..... Scott F. Minnich & Son
 Address..... Hagerstown, Md.

19. Sept. 17, 45 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 15, 1945 at 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9, 1945 to Sept 15, 1945 and that I last saw him alive on Sept 14, 1945

Immediate cause of death..... Pharyngeal heart disease

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... W. H. Fairman, M.D.

Address..... Hagerstown, Md. Date signed..... 9/17-45

RECEIVED
SEP 19 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09352 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
804 West Washington Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 804 West Washington Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

William K. Stotler

3. (b) Social Security Number

220-18-1278

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

B.(b) Name of husband or wife Mattie Stotler
6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) November 10, 1891

8. AGE: Years 53 Months 9 Days 23 If less than one day
.....hrs.min.

9. Birthplace Hagerstown, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Taxi Operator

11. Industry or business Owner

FATHER 12. Name Victor Stotler

13. Birthplace Hagerstown, Maryland

MOTHER 14. Maiden name Mary R. Blickenstaff

15. Birthplace Hagerstown, Maryland

16. Informant Mrs. William K. Stotler
Address Hagerstown, Maryland

17. Burial Date thereof Sept 7 - 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Broadfording Cemetery
Location Broadfording, Maryland

18. Funeral director C. M. Suter & Sons
Address Hagerstown, Maryland

19. Sept. 5, 1945 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3 1945, at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/1/45 to 9/3/45 and that I last saw him alive on 9/3/45

Immediate cause of death Coronary thrombosis DURATION long

Due to

Due to

Other conditions Hypertensive heart disease
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas H Bowers M. D. or other
Address Hagerstown, Md. Date signed 9/4/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 7 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-0

CERTIFICATE OF DEATH

Reg. Dist. No. 300

1. PLACE OF DEATH:

County Washington
 City or town Rural Sharpsburg Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 months
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Wash
 City or town Rural Sharpsburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rt 2
 (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Loie H. Stuckey

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 8. AGE: Years 68 Months 10 Days 8 It less than one day
 7. Birth date of deceased (mo., day, yr.) Oct 31 1876 6.(c) If alive, give age 57 years

9. Birthplace near Big Pool Wash. Md
 (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Samuel Roof
 13. Birthplace Cassandria Unknown
 MOTHER 14. Maiden name Cassandria Middle
 15. Birthplace Unknown

16. Informant Mrs Robert Betta
 Address Haguetown Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof Sept 11 1945
 (month) (day) (year)

Cemetery or crematory Stater's Chapel
 Location Hedgesville W. Va

18. Funeral director Scott & Munnich Son
 Address Haguetown Md

19. 9-10-45 (Date rec'd by registrar) CCF Beebe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1945 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about 11:00 to Sept. 9 1945
 and that I last saw her alive on Sept. 5-8 1945

Immediate cause of death Chronic myocarditis DURATION 7

Due to Arteriosclerosis and Hypertension T

Due to Chronic Interstitial Nephritis I yrs.
 Other conditions Chronic Interstitial Nephritis
 (Include pregnancy within 3 months of death)

Major findings of operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of.

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter H. Shealy M.D. M. D. or other

Address Sharpsburg, Md Date signed 9/9/45

RECEIVED
OCT 5 1945
BUREAU V.B.

COPY SENT TO Co. Health Officer DATE 10/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Bowman

09354

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 Days

Hospital, institution, or street address where death occurred:

Washington county HospitalHow long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 909 1/2 Maryland Ave
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

Ronald Lee Thomas3. (b) Social Security Number
None

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife --6. (c) If alive, give age -- years7. Birth date of
deceased (mo., day, yr.)April 13 1944

8. AGE:

Years

Months

Days

If less than one day

1418

hrs.

min.

9. Birthplace Hagerstown Wash. Co. Md.

(Town, county, and state)

10. Usual occupation

Infant11. Industry or business -

FATHER

12. Name

Kenneth Thomas

13. Birthplace

Keedysville Md

MOTHER

14. Maiden name

Hilda Bowers

15. Birthplace

Bakersville Md.16. Informant Mrs. Hilda Thomas

Address

Hagerstown Md.17. Burial
(Burial, cremation, or removal. Which?)Date thereof 9/3/45
(month) (day) (year)

Cemetery or crematory

Green Lawn Cemetery

Location

Williamsport Md.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.19. Sept 3 45
(Date rec'd by registrar)19. 45Phoebe Bowers

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1945 19 at 11.30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8/31 1945 to 9/1 1945
and that I last saw him alive on 9/1 1945

Immediate cause of death

Meningitis

DURATION

Due to

Type unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. Bowman

M. D. or other

Address Hagerstown Md. Date signed 9/3/45

RECEIVED

SEP 5 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

09355

CERTIFICATE OF DEATH



Reg. Dist. No. 304

1. PLACE OF DEATH:

County Wash. Co.City or town Harrocks Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wash.City or town Rural Harrocks
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Male Child Russel C. Trail

3. (b) Social Security Number

none.

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept. 17, 1945.

8. AGE:

Years

Months

Days

If less than one day

Stillborn hrs. _____ min. _____

9. Birthplace

Wash. Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

None

MOTHER FATHER

12. Name

Russel C. Trail

13. Birthplace

Bellegueuse Co. Md.

14. Maiden name

Bethel Spring

15. Birthplace

Bellegueuse Co. Md.

16. Informant

Russel Trail

Address

Harrocks R.D. Md.

17. (Burial, cremation, or removal - Which?)

Burial

Cemetery or crematory

Green Grove Cemetery

Location

Near Harrocks, Md.

18. Funeral director

Funerary - Harrocks

Address

Harrocks, Md.

19.

Sept 18 1945
(Date read by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 18 1945 at 1 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 17 1945 to Sept 18 1945and that I last saw him alive on Sept 17 1945

Immediate cause of death

Premature

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. M. ShafferAddress Harrocks Md Date signed 9/18/45

RECEIVED

SEP 21 1945

BUREAU V S

PLEASE, WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1228

CERTIFICATE OF DEATH

Reg. Dist. No. 119356 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?

3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 113 Alexander Street

(If rural, give LOCATION)

2.(c) If veteran, name war

3. (a) FULL NAME

William K. Turner

3. (b) Social Security Number

705-10-5293

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Salena K. Turner6. (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.)

March 22, 1888

8. AGE:

Years

Months

Days

If less than one day

5766

hrs.

min.

9. Birthplace

Elkton, Virginia

(Town, county, and state)

10. Usual occupation

R.R. Conductor

11. Industry or business

Western Maryland R.R.

FATHER

12. Name

Albert Turner

13. Birthplace

Elkton, Virginia

MOTHER

14. Maiden name

Susan Rinehart

15. Birthplace

Elkton, Virginia

16. Informant

Mrs. William K. Turner

Address

Hagerstown, Maryland

17.

RemovalDate thereof 9-29-45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Elkton Cemetery

Location

Elkton, Virginia

18. Funeral director

C. M. Suter & Sons

Address

Hagerstown, Maryland

19.

Sept. 29, 1945
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 28 - 1945, at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 25 - 1945 to Sept 28 - 1945
and that I last saw him alive on Sept 27 - 1945

Immediate cause of death

DURATION

Intestinal Obstruction3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 9/28/45

RECEIVED

OCT 2 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 124-C

CERTIFICATE OF DEATH

09357

★ Reg. Dist. No. 306

1. PLACE OF DEATH:

County Wash.
 City or town Smithsburg Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 78 yrs
 Hospital, institution, or street address where death occurred: -

How long in hospital or institution? -

3. (a) FULL NAME

May Bishop Wade.4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife -7. Birth date of deceased 4-18-18666. (c) If alive, give age - years8. AGE: Years 78 Months 10 Days - If less than one day - hrs. - min.9. Birthplace Smithsburg Md
(Town, county, and state)10. Usual occupation Retired Clerk.

11. Industry or business

12. Name E. Tracy Bishop13. Birthplace Smithsburg Md14. Maiden name Mary L. Bishop15. Birthplace Wash. Smithsburg Md16. Informant Hue. MontgomeryAddress Tampa, Florida17. Burial Burial Date thereof Sept. 21, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Smithsburg CemeteryLocation Smithsburg Md18. Funeral director Geo. B. HornerAddress Smithsburg Md19. Sept 19 1945 Geo. W. Ferguson
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wash.
 City or town Smithsburg Md
 (If outside city or town limits, write RURAL and give nearest town)

Street No. none
 (If rural, give LOCATION)

2. (a) If veteran, name war none

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1945 at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1945 to Sept 18 1945
 and that I last saw him alive on Sept 18 1945

Immediate cause of death Pulmonary Edema DURATION 2 hours

Due to chronic myomatosis 10 yrs
Factor - Sclerosis 10 yrs
Due to Diabetes is of liver 14 yrs

Other conditions -

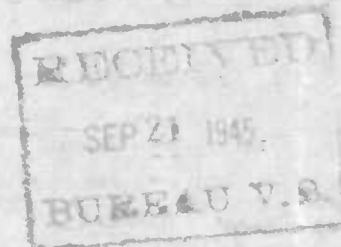
(Include pregnancy within 3 months of death)

Major findings of operations -Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE G. C. H. Ogle M.D.Address Smithsburg Date signed 9/15/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1066

CERTIFICATE OF DEATH

Reg. Dist. No. 0935

304

1. PLACE OF DEATH:

County WashingtonCity or town Hancock
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 yrs.

Hospital, institution, or street address where death occurred:

Blue Hill, Hancock, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County WashingtonCity or town Hancock
(If outside city or town limits, write RURAL and give nearest town)Street No. Blue Hill
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Clara Elizabeth Warvel

3.(b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife William Allen Warvel

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 18628. AGE: Years 82 Months 10 Days 3 If less than one day
hrs. min.9. Birthplace Darke County, Ohio
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name J. O. Winters13. Birthplace Ohio14. Maiden name Rhoda Brewer15. Birthplace Ohio16. Informant Geo. H. WarvelAddress 2405 Barclay St. Balto. Md.17. Burial Date thereof Oct. 4, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Beamsville CemeteryLocation Beamsville, Ohio18. Funeral director Charles R. BastAddress Hancock, Md.19. J. A. Heller
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30 1945 at 8:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1943 to 9-2 1945and that I last saw her alive on 9-2 1945Immediate cause of death Pulmonary Hemorrhage; DURATION 3 hoursdue to Arteriosclerosisnot due to tuberculosis.Due to embolismOther conditions Chronic Bronchitis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

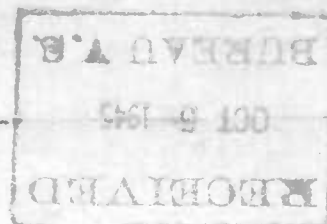
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Herbert R. Zimar M.D. M. D. or otherAddress Hancock, Md. Date signed 10-3-45



COPIES SENT TO Co. Health Officer ~~UNIT REGISTRATION~~ DATE 10/5/45